TN Division of TennCare

2018 MEMO

Date: September 2017
Subject: Update on the Tennessee Health Care Innovation Initiative

The following memo discusses the recommendations and corresponding improvements made to the Episodes of Care program in Tennessee for the 2018 performance period.

We greatly appreciate the feedback we have received from stakeholders over the past year, and especially those stakeholders who attended the Episodes Design Feedback Session meetings held on May 16, 2017. The meetings were an opportunity for members of the public from across Tennessee to comment on what is working well and areas for improvement in the design of the first 20 Episodes of Care. The meetings were held simultaneously in six cities across Tennessee (Chattanooga, Jackson, Johnson City, Knoxville, Nashville, and Memphis) and connected via videoconference to make it easier for the public to participate. Members of the public were also able to submit their feedback by email.

Based on the feedback received, we are making over 35 changes to the design of these Episodes of Care for calendar year 2018. These changes will first be reflected in reports released in August of 2018. Commercial and Medicare Advantage carriers may also choose to implement these changes but there may be differences in the clinical design of commercial episodes.

Stakeholder input from Tennessee providers, payers, patients, and employers has shaped the design of episodes of care and the other value-based payment strategies that make up Tennessee's Health Care Innovation Initiative. The Initiative has held over a thousand meetings with stakeholders to date and continues to regularly seek stakeholder input. In the Episodes of Care strategy, the design of each episode is informed by a Technical Advisory Group (TAG) composed of expert clinicians representing a diversity of relevant specialties, provider types, and urban and rural practices from across Tennessee.

The state received over one hundred pieces of feedback and worked diligently to address all recommendations. The feedback is organized by episode in alphabetical order. Each episode can contain two sections: 1) Feedback Accepted and 2) Feedback Not Accepted. Recommendations within the "Feedback Accepted" section refers to feedback that will be incorporated and reflected in the 2018 Detailed

Business Requirements (DBRs) and Configuration Files. Please note that some feedback may be accepted with modifications. Additionally, “Feedback Not Accepted” reflects feedback that was either not accepted as a change or will not be ready for implementation for the 2018 performance period.

For more information about episodes of care in Tennessee in general, go to http://tn.gov/tenncare/section/health-care-innovation.

All Episodes

Feedback Accepted

Comment: Protect the Quarterback from paying high penalties by revising the Stop-loss policy.
Response: The Stop-loss policy is in place to protect providers and provider groups[1] from paying back more than they are reimbursed by creating a high-cost cap to penalties. While this policy currently exists, the state is changing the rule from "A quarterback's penalty cannot exceed 100% the amount paid to the quarterback for all valid episodes in the performance period" to "A quarterback's penalty cannot exceed *25%* the amount paid to the quarterback for all valid episodes in the performance period." This means if a provider group is reimbursed $1,000 for all valid episodes, the provider group is only at risk to pay a maximum $250 penalty.

Comment: Quarterbacks should not have patients in more than one episode at a time.
Response: Throughout the Feedback Session, multiple comments were made regarding two or more episodes running concurrently for the same patient. For example, we had recommendations to exclude one of the two episodes for the following situations: cholecystectomy and appendectomy, cholecystectomy and EGD, colonoscopy and EGD, perinatal and skin and soft tissue infection, and ADHD and ODD. We have made some of these changes as suggested, please see the relevant episode for more information. In addition we are working to create a general approach to multiple episodes running concurrently which will be effective for the 2018 performance period.

Comment: Exclude health departments that are Federally Qualified Health Clinics (FQHCs).
Response: An episode will be excluded if a trigger diagnosis occurs in a Federally Qualified Health Clinic (FQHCs). Exclusions for FQHCs are based on Place of Service and Billing type. If coding is correct, all FQHCs will not be included in the episodes of care program.

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[1]*Throughout the memorandum, references to "providers" can be substituted with individual providers, provider groups or facilities. The provider, provider group or facility Quarterbacks are identified by the Tax ID or Contracting ID.*

Comment: Only include specific medications in all episodes.
Response: Some stakeholders were concerned that unrelated medications are being included in the cost of episodes. The Detailed Business Requirements (DBRs) for all episodes defines what medications to include based on type of medication and time of fill. For example, inpatient episodes include all medications during the triggering visit or hospitalization, which is appropriate because the medications are part of the treatment that the patient is receiving. Outpatient episodes on the contrary include only specific medications as defined in the configuration file. Section 2.3.4 of the DBR for each episode documents the types of medications included in the pre-trigger, trigger and post-trigger window. These distinctions are generally based on feedback from the Technical Advisory Group (TAG). It is important to note that all medications prescribed for that patient that match the DBR rules will be included in spend regardless of the provider that prescribed the medications.

In additional to general concern about included medications, the state received feedback about inclusion of specific types of medications. We have made changes based on some of these recommendations, which are included in the specific episode section.

Feedback Not Accepted

Comment: Create a low-volume exclusion for all episodes.
Response: It was recommended that Quarterbacks with a low volume of episodes should not be held financially accountable under the Episode of Care model. The state believes that providers should be held accountable for all care under the Episode of Care model.

However, if a provider or provider group has a penalty at the end of the year and feels that they have special circumstances, such as only a few valid episodes or believes that one of more of their episodes cannot be fairly compared to others and contributed to the penalty, then that provider or provider group can ask the respective TennCare Managed Care Organization (MCO) for reconsideration for the penalty. On a case-by-case basis, the MCOs can review the situation and decide whether there is a reason not to collect the penalty.

Please also note, beginning in 2016 performance period, providers or provider groups with risk sharing payment of less than $100 are not penalized. All providers / provider groups will continue to receive reports, but only those providers / provider groups with a final risk sharing payment in excess of $100 will be required to make a shared risk payment back to the MCO. Providers / provider groups with a shared savings reward of any amount will continue to receive the reward payment.

Comment: Display greater level of detail on the specific diagnosis codes that comprise a patient's risk score.
Response: In Tennessee, carriers are sharing more information about their risk adjustment model for episodes than is available for many other risk adjustment models in use elsewhere. Providers can go to carriers' websites and see how variation in episode cost due to a patients' demographic information (such as age and sex) and comorbidities are accounted for in the model. This information includes a list of the demographic categories and comorbidities and the factor by which the cost will be adjusted. Here is how to view that information:

- **Amerigroup:** https://providers.amerigroup.com/pages/tn-2012.aspx [Under the "Tennessee Episodes of Care" tab].
- **BlueCross BlueShield of Tennessee:** https://bluecare.bcbst.com/forms/Provider%20Information/Risk_Factors_and_Weights.pdf
- **United Healthcare:** http://www.uhccommunityplan.com/health-professionals/tn/Episodes-of-Care-PCMH-TN-Health-Link.html
- **Cigna:** 615-595-3663 or email Megan.Higdon@Cigna.com

Some stakeholders would like to see the specific diagnosis codes (e.g. ICD-10) that define the comorbidities in the carriers risk adjustment model. These diagnosis codes are generally proprietary to the model developers, and by contract they cannot be shared. We believe that the level of transparency from the carriers is the best balance of giving the providers the information that they need while allowing the carriers to use the best available risk adjustment models.

Overall, the level of detail in these reports allows providers to know what diagnosis or condition is included in risk adjustment without revealing proprietary information.

Comment: Exclude non-compliant patients from all episodes.
Response: All episodes include patient and business exclusions that aim to protect the provider from being held responsible for decisions made by the patient. For example, an episode is excluded if a patient has a discharge status of "left against medical advice or discontinued care" on any inpatient or outpatient claim during the episode window. The goal of the episodes program, however, is to better coordinate care and education patients to improve quality care and reduce expensive, preventable care. While patient non-compliance is frequently an issue, providers do have the opportunity to positively influence patient behavior. Creating a separate exclusion on patient non-compliance could lead to perverse incentives.

Acute Asthma Exacerbation

Feedback Accepted

Comment: Exclude episodes with a diagnosis of sickle cell disease.
Response: Clinical experts and recent studies have shown that asthma may complicate a patient's sickle cell disease leading to more complex care. Since the patient journey for acute asthma exacerbation is unique for a patient with this condition, sickle cell disease will be excluded from the acute asthma exacerbation episode.

Comment: Include inpatient claims for the "appropriate medications within the trigger and post-trigger window" quality metric in addition to outpatient and professional claims.
Response: The goal of the "appropriate medications within the trigger and post-trigger window" quality metric is to determine the percent of episodes where an oral and/or injectable corticosteroid is administrated or filled during the triggering visit or stay and/or 30-days after the index visit or stay. As discussed in the 2016 Episodes Design Feedback Session memorandum, the guidelines for medication use during an acute asthma exacerbation recommend giving early systematic

glucocorticoids (e.g. prednisone, prednisolone, methylprednisolone, beclomethasone, betamethasone, dexamethasone, hydrocortisone and triamcinolone) to all patients who have a moderate or severe exacerbation. Since these medications are often prescribed in an inpatient hospital setting, inpatient professional claims will be included in the quality metric to better capture appropriate oral and/or injectable corticosteroids.

Attention Deficit and Hyperactivity Disorder (ADHD)

Feedback Accepted

Comment: Change the current temporary Level I Case Management clinical exclusion to a permanent clinical exclusion.
Response: The intent of the Level I Case Management temporary clinical exclusion was to give providers an additional year to improve their coding to more accurately capture clinical exclusions and risk factors. Improved coding will allow higher risk patients to be excluded based on a diagnosis (e.g. bipolar disorder) rather than the treatment. However, while Level I Case Management will not be made a permanent exclusion, the episode will continue to have a Level I Case Management clinical exclusion for ADHD in calendar year 2018. It will be revisited for performance period 2019.

Comment: Improve the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion by adding additional diagnosis codes to the definition.
Response: To ensure the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion is correctly excluding patients with this diagnosis, additional codes were added to the configuration file. This improvement also makes the DMDD exclusion the same for the ADHD and ODD episodes.

Comment: Exclude patients with a diagnosis of Tourette's Disorder from the ADHD episode.
Response: Since a diagnosis of Tourette's Disorder does not change the patient journey for ADHD care, Tourette's Disorder will not be a clinical exclusion. However,

to account for higher cost due to Tourette's Disorder, the diagnosis is listed as a proposed risk factor for the ADHD episode.

Feedback Not Accepted

Comment: Incorporate non-claims based data, such as school data, into quality metrics for the ADHD episode.
Response: The state recently secured the capacity to integrate non-claims based data into the quality metrics and is working with various organizations to add additional non-claims-based quality measures. School-based data is one area that we will investigate.

Comment: Expand the types of treatments and programs (e.g. Regional Intervention Program (RIP)) that are included in the Minimum Care Requirement and Utilization of Therapy quality metrics.
Response: The overarching goal of the Minimum Care Requirement and Utilization of Therapy quality metrics is to hold providers and provider groups accountable for providing appropriate and effective care. While community interventions are important forms of treatment for patients with ADHD, they are often not provided by licensed professionals or physicians and patients still require other forms of treatment. Additionally, these programs are not captured in claims. For these reasons, community-based treatments, such as RIP, will not be included in the quality metric definitions.

Comment: Revise the "Long-acting stimulants" and "Utilization of therapy" quality metrics for children ages 4 and 5 years to prevent perverse incentives.
Response: Stakeholders were concerned that the "Long-acting stimulants" and "Utilization of therapy" quality metrics for 4 and 5 year olds were incentivizing both medication and therapy, therefore creating confusion for the Quarterbacks. This is not the case, however. As discussed by the Technical Advisory Group (TAG) in November 2016, most children aged 4 or 5 years old receive only therapy to treat ADHD. If this is the case and no medication is prescribed, the denominator of the "long-acting simulants" quality metric will be zero and will not be counted against the Quarterback for gain share eligibility. On the other hand, if the child does need medication, the "long-acting stimulants" quality metric will be activated. The

percentage of long-acting stimulants quality metric was added to avoid rewarding short-acting stimulants over long-acting stimulants due to lower costs when medication is appropriate. Overall, these quality metrics do not interact and correctly capture different types of care.

Comment: Include diagnoses from Mobile Crisis Units for exclusions and/or risk adjustment for the ADHD episode.
Response: We are further investigating this recommendation to use diagnoses from Mobile Crisis units. Information from Mobile Units could be used to capture diagnoses for exclusion and risk adjustment if these diagnoses are not captured by a different provider. It is important to note that this may impact a limited set of episodes and Mobile Crisis units may not be credentialed to render a diagnosis.

Additionally, the data from Mobile Crisis units could be accessed either through claims or other data sources. While claims data would be easier to integrate and Mobile Crisis Units are required to submit claims to the Managed Care Organizations (MCOs), not all Mobile Crisis teams consistently submit claims. TennCare is working with the Department of Mental Health and Substance Abuse Services to determine the feasibility of incorporating Mobile Crisis data into episodes.

Comment: Exclude patients from the ADHD episode who have an encounter with a Mobile Crisis Unit.
Response: In addition to the limitations with the Mobile Crisis Unit data discussed above, the Episodes of Care program does not typically exclude on the provision of a service since that service does not directly signal a unique patient journey. For example, acute episodes are not excluded if a patient needed an ambulance. Therefore, the fact that a patient saw a Mobile Crisis Unit is not a reason for a clinical exclusion.

Comment: Remove Family Support Services from Quarterback attribution for the ADHD episode.
Response: A stakeholder was concerned that Family Support Service (FSS) specialists were being attributed as Quarterbacks for the ADHD episode. Since FSS specialists are usually unlicensed and serve as community support, the state agrees that these specialists are not in the best position to influence care and therefore

should not be Quarterbacks. After analysis, however, there has been no evidence that FFS specialists have ever been assigned as Quarterbacks. The problem will be addressed if it arises.

Bariatric Surgery

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Comment: Decrease the duration of the post-trigger window from 90 days.
Response: The post-trigger window of the Bariatric episode is 30 days, not 90 days. The Technical Advisory Group (TAG) recommended a post-trigger window duration of 30 days to accurately capture the follow-up period in which a Quarterback is responsible for influencing care and reducing costs.

Feedback Not Accepted

Comment: Change the Quarterback from the physician or the physician group to the facility.
Response: The Technical Advisory Group (TAG) recommended the physician or physician group to be the Quarterback for the Bariatric episode. The physician group is in the best position to influence the cost and quality of a bariatric episode, and also generally advises the patient in which facility the surgery should be performed. For this reason, in all elective procedural episodes created to date the physician performing the procedure has been assigned as the Quarterback. The Bariatric episode will continue to have the physician or physician group as the Quarterback.

Comment: Request that the "Appropriate procedural choice" quality metric be changed from informational to gain sharing for calendar year 2018.
Response: The "Appropriate procedural choice" quality metrics measures the percent of valid episodes where patients with metabolic and/or diabetes receive Roux-en-Y gastric bypass (RYGB). Based on the first preview period for Bariatric Surgery, a low percentage of Quarterbacks had data for this quality metric. Due to the lack of data, it is currently not recommended to change this metric to gain sharing. In the future, we will seek further discussion from multiple Bariatric providers about possibly moving this metric to being tied to gain sharing.

Cholecystectomy

Feedback Not Accepted

Comment: Exclude the episode or the related spend if the patient is diagnosed with one or more sexually transmitted diseases (STDs).
Response: Some providers were concerned that the development of a sexually transmitted disease (STD) should be excluded because it could lead to more costly treatment. An STD does not meet the standard of creating a different patient pathway. An STD is one of many factors that could have some impact on the cost of an episode, but the potential for a provider group to have a patient with one of these many factors is about the same. There are several aspects of the episode program design that mitigate these types of risk for the provider group. One aspect is that the provider group is being held accountable for the average of all episodes in a year, mitigating the impact of any one episode. Another element is that very high cost episodes are excluded if the total adjusted cost of the episode is more than three standard deviations above the adjusted mean. For these reasons, STDs will not be a clinical exclusion or excluded from spend.

Colonoscopy (Screening and Surveillance)

Feedback Accepted

Comment: Split the "prior colonoscopy" quality metric into two metrics: 1) "prior screening colonoscopy" and 2) "prior diagnostic colonoscopy."
Response: For calendar year 2017 and earlier, the "prior colonoscopy" quality metric measured the percent of valid episodes with a prior screening, surveillance, or diagnostic colonoscopy within 365 days before the triggering colonoscopy. A stakeholder recommended creating two separate quality metrics: "prior screening and surveillance colonoscopy" and "prior diagnostic colonoscopy." This allows Quarterbacks to better pinpoint potential sources of overutilization within care. Overall, the "prior colonoscopy" quality metric will be replaced with a "prior screening and surveillance colonoscopy" quality metric and "prior diagnostic colonoscopy" quality metric.

Comment: Remove all codes unrelated to a colonoscopy from the configuration file.
Response: The screening and surveillance colonoscopy episode is designed to capture care before, during and after the colonoscopy procedure. To more accurately fulfill the episode's intended goal, codes unrelated to the colonoscopy process were removed from the configuration file (code sheet). For example, codes related to systems other than the gastrointestinal system are no longer included in the episode logic. While inclusion of these unrelated codes will most likely not impact the overall cost as they rarely occur concurrently with a screening and surveillance colonoscopy, the codes were removed to improve clarity and intent of the episode.

Feedback Not Accepted

Comment: Remove all inpatient claims from the cost for the colonoscopy episode.
Response: The screening and surveillance colonoscopy episode is not intended to capture diagnostic colonoscopies. However, some inpatient services can be related to a screening and surveillance colonoscopy. For example, some patients have screening and surveillance colonoscopies performed in an inpatient hospital

setting. To avoid creating an incentive to not use inpatient facilities when appropriate, spend associated with inpatient claims are *not* included on the day of the procedure (also called the episode trigger window).

Inpatient cost should also be included in the episode to hold providers and provider groups accountable for complications from the colonoscopy, such as perforation or bleeding. Therefore, inpatient claims filed after the procedure day (post-trigger window) will continue to be included in the episode cost. Overall, the colonoscopy will continue to capture inpatient spend when appropriate.

Coronary Artery Bypass Grafting (CABG)

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Feedback Not Accepted

Comment: Revise the "Admission within the post-trigger window" quality metric to require a confirming diagnosis related to the CABG procedure.
Response: The current logic only includes readmissions with a relevant diagnosis to the CABG procedure in the calculation of the quality metric. No change will be made to the quality metric.

Endoscopy (Esophagogastroduodenoscopy (EGD))

Feedback Accepted

Comment: Exclude either the EGD or Colonoscopy episode if they overlap during the trigger window.
Response: If appropriate, providers may perform a screening and surveillance colonoscopy and an EGD at the same time since it is preferred by the patient and provider. For example, the patient only needs to be put under anesthesia once rather than twice for each procedure. About 20 percent of colonoscopy episodes overlap with an EGD episode during the trigger window. Therefore, a screening and surveillance colonoscopy will be a clinical exclusion for the EGD episode if it occurs during the trigger window. The Quarterback will still be held accountable for the colonoscopy episode, but not the EGD episode.

GI Hemorrhage

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Comment: Revise the "Admission within the post-trigger window" quality metric to require a confirming diagnosis related to the GI hemorrhage.
Response: The intent of the "Admission within the post-trigger window" quality metric is to include only readmissions with a diagnosis relating to a GI hemorrhage in the calculation of the metric. Therefore, the quality metric logic for "Admission within the post-trigger window" will be revised to require a confirming diagnosis of a GI hemorrhage. This change matches the logic used in CABG and Valve Repair and Replacement episodes.

Oppositional Defiant Disorder (ODD)

Feedback Accepted

Comment: Improve the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion by adding addition diagnosis codes to the definition.
Response: To ensure the Disruptive Mood Dysregulation Disorder (DMDD) clinical exclusion is correctly excluding patients with this diagnosis, additional codes were added to the configuration file. This improvement also makes the DMDD exclusion the same for the ODD and ADHD episodes.

Comment: Exclude patients with a diagnosis of Tourette's Disorder from the ODD episode.
Response: Since a diagnosis of Tourette's Disorder does not change the patient journey for ODD care, Tourette's Disorder will not be a clinical exclusion. However, to account for higher cost due to Tourette's Disorder, the diagnosis is listed as a proposed risk factor for the ODD episode.

Feedback Not Accepted

Comment: Include diagnoses from Mobile Crisis Units for exclusions and/or risk adjustment for the ODD episode.
Response: We are further investigating this recommendation to use diagnoses from Mobile Crisis units. Information from Mobile Units could be used to capture diagnoses for exclusion and risk adjustment if these diagnoses are not captured by a different provider. It is important to note that this may impact a limited set of episodes and Mobile Crisis units may not be credentialed to render a diagnosis.

Additionally, the data from Mobile Crisis units could be accessed either through claims or other data sources. While claims data would be easier to integrate and Mobile Crisis Units are required to submit claims to the Managed Care Organizations (MCOs), not all Mobile Crisis teams consistently submit claims. TennCare is working with the Department of Mental Health and Substance Abuse Services to determine the feasibility of incorporating Mobile Crisis data into episodes.

Comment: Exclude patients from the ODD episode who have an encounter with a Mobile Crisis Unit.
Response: In addition to the limitations with the Mobile Crisis Unit data discussed above, the Episodes program does not typically exclude on the provision of a service since that service does not directly signal a unique patient journey. For example, acute episodes are not excluded if a patient needed an ambulance. Therefore, the fact that a patient saw a Mobile Crisis Unit is not a reason for a clinical exclusion.

Comment: Remove Family Support Services from Quarterback attribution for the ODD episode.
Response: A stakeholder was concerned that Family Support Service (FSS) specialists were being attributed as Quarterbacks for the ODD episode. Since FSS specialists are usually unlicensed and serve as community support, the state agrees that these specialists are not in the best position to influence care and therefore should not be Quarterbacks. After analysis, however, there has been no evidence that FFS specialists have ever been assigned as Quarterbacks. The problem will be addressed if it ever does arise.

Comment: Exclude episodes with cannabis and alcohol abuse from the ODD episode.
Response: Patients with behavioral health conditions often have comorbid substance abuse. To ensure providers and provider groups are still accountable for the care of these patients, substance abuse will not be a clinical exclusion. However, various forms of substance abuse (e.g. alcohol, cannabis, tobacco) are proposed risk factors.

Comment: Include Tennessee Health Link (THL) services as part of the Minimum Care Requirement quality metric.
Response: The Minimum Care Requirement quality metric aims to capture specific treatment provided to the patient. While THL helps to coordinate care for patients with significant behavioral health needs, it is not a treatment in itself. Since THL is a service provided, it will not be included in the Minimum Care Requirement for the ODD episode.

Perinatal

Feedback Accepted

Comment: Update the Gestational Diabetes screening Quality Metric to include the ICD-10 diagnosis code O24 for Diabetes mellitus in pregnancy, childbirth and the puerperium.
Response: Currently, the gestational diabetes screening quality metric contains Endocrine or "E" ICD-10 diagnosis codes indicating a diagnosis of diabetes mellitus. In addition to "E" codes there are "O" ICD-10 diagnoses codes that define diabetes mellitus in pregnancy, childbirth and puerperium. To ensure that patients with existing diabetes, who will not be screened for gestational diabetes, are captured in this quality metric, the ICD-10 diagnosis code, O24, and ICD-9 diagnoses code 648.0 will be added to the quality metric definition under "gestational diabetes diagnoses."

Comment: Update the list of diagnoses to test for in the risk adjustment process.
Response: Stakeholders recommended adding additional risk factors to test for in the perinatal episode to better account for sources of variation between patient journeys and make fair comparisons. For example, such risk factors include abnormal findings on antenatal screening of mother and infections of the genitourinary tract in pregnancy. These risk factors will be tested for statistical significance in the risk adjustment model by each of the Managed Care Organizations (MCOs) on an annual basis. However, since factors such as reimbursement rates and the patient population can impact the significance of a suggested risk factor, the risk factors may vary between MCOs.

Comment: Exclude the episode for patients who are victims of rape or statutory rape.
Response: While the state agrees that patients with a history of rape or statutory rape may have more medical needs, the perinatal episode aims to hold providers and provider groups accountable for appropriate prenatal care. To ensure that valid episodes can be fairly compared in terms of both cost and patient journey, rape was added as risk factor for the Managed Care Organizations (MCOs) to test.

Comment: Exclude the spend related to a Skin and Soft Tissue Infection (SSTI) episode from the Perinatal episode.
Response: It is possible that the Quarterback of a perinatal episode, usually the OBGYN, will also diagnose a skin and soft tissue infection (SSTI). While it is important to hold the Quarterback accountable for the care around the SSTI, allowing both episodes to trigger can lead to duplicate rewards or penalties. Therefore, a live birth 60 days prior to the SSTI trigger or during the episode window will cause the SSTI episode to be excluded or invalid.

Comment: Remove 58 ICD-10 codes related to malignant neoplasms and neoplasms for male patients from the perinatal episode.
Response: The current version of the perinatal episode specifies codes for malignant neoplasms and neoplasms of male anatomy as "Malignant Cancer" and "Active Cancer Management" clinical exclusions. While diagnoses of cancer for males are not part of the perinatal patient journey, these codes are in the episode logic as *exclusions* to ensure they are not incorrectly captured in episode spend. Therefore, we will not remove the codes from the exclusion list as a safe guard for the episode. Additionally, Male diagnoses codes related to genetic testing will remain included in the episode spend as they are important for informing the health of the mother and baby.

Comment: Risk adjust the perinatal episode for patients with obesity.
Response: Obesity is considered a risk factor for complications in pregnancy. Currently, all three Managed Care Organizations (MCOs) risk adjust for obesity in the perinatal episode. Since this recommendation is currently implemented, no change will be made. To review all risk factors included in each episode, please visit the website for each TennCare MCO and Cigna:

- **Amerigroup:** https://providers.amerigroup.com/pages/tn-2012.aspx [Under the "Tennessee Episodes of Care" tab].
- **BlueCross BlueShield of Tennessee:** https://bluecare.bcbst.com/forms/Provider%20Information/Risk_Factors_and_Weights.pdf
- **United Healthcare:** http://www.uhccommunityplan.com/health-professionals/tn/Episodes-of-Care-PCMH-TN-Health-Link.html
- **Cigna:** 615-595-3663 or email Megan.Higdon@Cigna.com

Feedback Not Accepted

Comment: Exclude patients who had a previous C-Section from the C-section quality metric. It was also recommended that the quality metric exclude patients from the quality metrics based on scars (O34.211 Low Transverse Scar from previous C-section, O34.212 Vertical scar from previous C-section and O34.29 Uterine Scar from other previous surgery).
Response: While a previous C-Section is one of many reasons a patient may be at higher risk for a second C-Section, The quality metric for C-section rate is set to allow for a relatively high proportion of C-sections (41 percent in 2017), therefore the provider has the ability to still meet the quality metric and perform C-sections when clinically necessary.

Furthermore, while a stakeholder's recommendation to exclude on codes for scarring is an interesting approach, it may not consistently capture patients who have had previous C-sections.

Comment: Exclude the episode if the patient had a previous C-Section.
Response: The patient journey of a woman in the perinatal episode is a low to medium-risk pregnancy with the birth of a live baby. The episode contains exclusions and risk factors to ensure that patients with unique patient journeys are not included in the episode and that fair comparisons can be made across episodes. However, since a woman with a previous C-Section does not have a unique overall patient journey the Quarterback should continue to be held accountable for the care they provide. Therefore, a woman with a previous C-Section will continue to be a valid episode when appropriate risk adjustment can be made.

Comment: Exclude patients who deliver prior to 35 weeks from the Group B streptococcus screening quality metric or update the Group B streptococcus screening quality metric to capture births that occurred before 35 weeks.
Response: Stakeholders are concerned that patients who deliver earlier than 35 weeks are less likely to receive a Group B streptococcus screening since the test is not as accurate 5 weeks before term, the outcome of the quality metric may be impacted. Currently, there is no data available to show the gestational age of the

baby at time of delivery since the mother's and baby's claims cannot be linked. To account for early delivery, the threshold for the quality metric is not set at 100 percent to allow quarterbacks to still pass the quality metric without all patients receiving the screening. In future years, it may be possible to link the mother's and baby's claims data and therefore make this change to the quality metric.

Comment: Exclude genetic testing from episode spend.
Response: A stakeholder was concerned that since genetic testing is expensive, providers or provider groups will not provide genetic testing in order to reduce episode costs. There is evidence, however, that genetic testing is over-utilized. Therefore, not holding providers or provider groups accountable for such services will be a loss of a significant source of value. Additionally, since gain and risk sharing is determined by relative spend between other Quarterbacks with perinatal episodes, a provider will not be at risk of a penalty if they perform a clinically appropriate amount of genetic testing. For these reasons, genetic testing will remain as an included service in the perinatal episode.

Comment: Change the perinatal episode trigger from live birth to positive pregnancy test.
Response: Stakeholders were concerned that since the episode assumes a 40 week gestation due to the length of the pre-trigger window, spend may be included from time before the woman was pregnant if she delivered prior to 40 weeks. While it is possible that the pre-trigger window may be longer than the pregnancy, spend is only included if it is directly related to pregnancy. Therefore, if the woman is not pregnant, she should not have a diagnosis for pregnancy and the associated costs would then not be included in the episode.

Additionally, it is not feasible to trigger on the first positive pregnancy test since that event is not always captured in medical records and/or claims.

Comment: Change the Quarterback from the physician or the physician group to the facility.
Response: The Technical Advisory Group (TAG) recommended the provider or provider group to be the Quarterback since they are in the best position to influence the cost and quality of care in the perinatal episode. The perinatal episode will continue to have the provider or provider group as the Quarterback.

Comment: Include the outcome of the baby in the perinatal episode as a quality metric, exclusion or other aspect of the episode's design.
Response: It was recommended that the health of the baby should be captured in the perinatal episode. In future years, when it may be possible to link the mother's and baby's claims data, the state plans to integrate the perinatal and neonatal episodes to create aligned accountability between the perinatal and neonatal quarterbacks.

Comment: Remove all spend related to Maternal Fetal Medicine (MFM) specialists from the episode.
Response: Maternal Fetal Medicine (MFM) services are frequently included in perinatal episodes. In fact, about 40 percent of the perinatal episodes had MFM services included in the CY 2016 TennCare data. If MFM costs were excluded from spend, the episodes would still not be comparable to episodes where no services were excluded. In future years, the state plans to integrate the perinatal and neonatal episodes to better align the incentives across the MFMs, OB/GYNs and neonatologists. Overall, MFM spend will continue to be included in the episode spend.

Pneumonia (PNA)

Feedback Accepted

Comment: Exclude episodes with a diagnosis of sickle cell disease.
Response: Clinical experts and recent studies have shown that patients with sickle cell disease may require more complex care for pneumonia. Since the patient journey for pneumonia is unique for a patient with this condition, sickle cell disease will be excluded from the pneumonia episode.

Comment: Exclude episodes with a diagnosis of bronchiolitis.
Response: Stakeholders were concerned that bronchiolitis and pneumonia cannot be fairly compared since they are unique disease processes. A diagnosis of bronchiolitis is not made in a patient over the age of 2 years, whereas as pneumonia can be diagnosed in both pediatric and adult populations. Since the patient journey for bronchiolitis cannot be fairly compared to pneumonia, the age parameters will be revised to exclude patients under the age of 18 years old. This will ensure that bronchiolitis will be excluded from the pneumonia episode. However, since bronchiolitis is a high-volume episode and includes various sources of value for cost and quality, a new episode called "pediatric acute lower respiratory infection" will be designed in the fall of 2017 (wave 8) to capture bronchiolitis.

Feedback Not Accepted

Comment: Include the cost related to Synagis (Palivizumab) in the pneumonia episode.
Response: One provider gave the recommendation to remove the cost associated with Synagis, an injection used to prevent respiratory syncytial virus (RSV), from the pneumonia episode. After deeper analysis, it was determined that this vaccination was clinically appropriate at times and should be included in spend. By including the cost related to Synagis in the pneumonia episode, providers are incentivized to only administer such injection when medically appropriate.

Respiratory Infection

Feedback Accepted

Comment: Remove all codes unrelated to a respiratory infection, especially medications, from the configuration file.
Response: The respiratory infection episode is designed to capture care during and two weeks after diagnosis. Therefore, medications unrelated to a respiratory infection will be removed from the spend inclusion logic. For example, codes related to chemotherapeutic agents will no longer be included in the episode spend. All codes in the configuration file were reviewed by clinical experts and changes were made when appropriate.

Feedback Not Accepted

Comment: Include the cost related to Synagis (Palivizumab) in the respiratory infection episode.
Response: One provider gave the recommendation to remove the cost associated with Synagis, an injection used to prevent respiratory syncytial virus (RSV), from the respiratory infection episode. After deeper analysis, it was determined that this vaccination was clinically appropriate at times and should be included in spend. By including the cost related to Synagis in the respiratory infection episode, providers are incentivized to only administer such injection when medically appropriate.

Total Joint Replacement (TJR)

Feedback Accepted

Comment: Update the "Dislocations or Fractures" quality metric to include only codes related to the lower extremities.
Response: The Total Joint Replacement (TJR) episode is designed to capture the care provided to a patient before and after receiving a total knee or hip replacement. To accurately capture the quality metric "Dislocations or Fractures," which measures the percentage of valid episodes with a dislocation or fracture in the post-trigger

window, codes that affect the spine and upper extremities (i.e. above the hip and pelvis) will no longer be included in the definition of the quality metric.

Comment: Remove codes from the "Dislocations or Fractures" quality metric that were not related to dislocations or fractures.
Response: To further improve the accuracy of the "Dislocations or Fractures" quality metric for the TJR episode, codes not related to a dislocation or fracture were removed from the definition. For example, arthritic conditions are no longer included in this metric.

Urinary Tract Infection (UTI) – Inpatient

Feedback Accepted

Comment: Exclude episodes with a diagnosis of sickle cell disease.
Response: Clinical experts and recent studies have shown that patients with sickle cell disease may require more complex care for inpatient urinary tract infections (UTI). Since the patient journey for inpatient UTI is unique for a patient with this condition, sickle cell disease will be excluded from the inpatient UTI episode.

Feedback Not Accepted

Comment: Ensure that the UTI inpatient episode contains inpatient related facility and professional charges.
Response: There was concern that the UTI inpatient episode was not correctly capturing spend associated with inpatient care. Based on our analysis, it was determined that the UTI inpatient episode is correctly capturing inpatient facility and professional charges and therefore, no change will be made. It is possible, however, that miscoding of claims can lead to errors in calculating the spend associated with the "inpatient" care category on the reports. If providers are seeing extremely low inpatient spend on their reports and are concerned, please contact the respective Managed Care Organization (MCO):

TennCare Managed Care Organizations (MCOs):

- **Amerigroup:** 615-232-2160
- **BlueCross BlueShield of Tennessee:**
  - 800-924-7141 (Option 4)
  - Contact your PRC: http://www.bcbst.com/providers/mycontact/?nav=calltoaction.
- **United Healthcare:** 615-372-3509

Cigna: 615-595-3663 or email Megan.Higdon@Cigna.com

Urinary Tract Infection (UTI) – Outpatient

Feedback Accepted

Comment: Exclude allergy medications from the episode spend for a UTI outpatient episode.
Response: Since the UTI outpatient episode captures only outpatient care, there is a defined list of specific included medications both within the trigger and post-trigger window. Multiple pharmacists reviewed the list of medications and determined that though antihistamines traditionally are used to treat allergies, they have local pain relieving and anti-itch properties and can be used in combination medications to treat a urinary tract infection. While those combination medications will not be removed from the included spend list, oral medicinal mouthwashes, commonly known as "magic mouthwash," that contain a combination of antifungal and/or antibiotics and an antihistamine are removed from the included spend list (HIC3 codes: W3E, W3G, W3F).

Comment: Exclude patients diagnosed with spina bifida and/or paralysis from the UTI outpatient episode.
Response: There was concern from providers that patients with spina bifida and paralysis have a unique patient journey and have more complex urinary tract infections due to indwelling catheterization. Since diagnoses of spina bidifa and paralysis can range from mild to severe, a patient may not require an indwelling catheter and therefore will not have a unique patient journey for a UTI. However, to

account for the complexity of treating patients with indwelling catheters, the presence or complication of an indwelling catheter is now a clinical exclusion from the UTI outpatient episode.

Comment: Remove codes unrelated to a diagnosis of an outpatient UTI from the list of included "Pathology and laboratory" spend under the "Imaging and Testing" spend subdimension.
Response: To further improve the episode, pathology and laboratory codes not related to the UTI diagnosis were removed from spend. For example, CPT codes related to coagulation time of the blood are no longer included in spend.

Comment: Ensure that only claims with a UTI confirming diagnosis are included in spend for the "Imaging and Testing" subdimension.
Response: Since a UTI is a common primary care diagnosis, providers often perform additional unrelated tests and services during the same visit as the UTI diagnosis. For example, a provider might do a wellness examination on the patient and diagnose a UTI during the examination. Therefore, in addition to removing specific codes as described above, the "Imaging and Testing" codes will now require a confirming diagnoses of a UTI to be included in spend. This logic will function similarly to the "Evaluation and Management" spend inclusion rules.

Valve Repair and Replacement

Feedback Accepted

Comment: Add CPT code 99024 for post-surgical follow-up to the "Follow-up care within the post-trigger window" quality metric definition.
Response: To ensure the quality metric was capturing all post-surgical follow-up care, CPT code 99024 was added to the quality metric definition. This CPT code is a zero amount, global spend code.

Feedback Not Accepted

Comment: Revise the "Admission within the post-trigger window" quality metric to require a confirming diagnosis related to the Valve Repair and Replacement.
Response: The current logic only includes readmissions with a relevant diagnosis to the Valve Repair and Replacement procedure in the calculation of the quality metric. No change will be made to the quality metric.